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Social Death

Review for QJM

Erica Borgstrom, 2016

Abstract

This review will outline various ways in which the notion of 'social death' can be understood, and how they can be related to clinical practice. The idea of social death is used to analytically represent how someone can be identified and treated as if they are ontologically deficient – meaning that they are not seen as being 'fully human.' This impacts on their position within society and how they are interacted with. This review will consider three examples of social death - often distinguished from physical or biological death - that are important for clinical practice: loss of agency and identity; treating people as if they are already dead; and, rituals and bereavement. Recognising that a distinction between social and biological death may not always be helpful, this review will suggest ways in which healthcare practitioners can minimise the likelihood of inadvertently treating someone as 'socially dead'.

Introduction

Death is considered to be universal, but when and how it is defined can vary. Social death is used to describe the ways in which someone is treated as if they were dead or non-existent. Social death is distinguished from biological or physical death: when the body is considered to have died and ceased functioning for life. Social death can occur before or after physical death. There have been several studies that use the concept of social death to reflect on how people can be treated as if they are already dead within clinical and social care settings. This has consequences for the kinds of treatment and care provided. This article is a review of the concept of social death and outlines several examples relevant to clinical practice.

Definitions of social death

The idea of social death crops is used to refer to a wide variety of situations from experiences of illness and dying, to responses to grief, to how sub-sections of the population are treated differently.¹⁻³ Králová has identified three characteristics often found in definitions of social death, each of which suggests that the concept represents compromised well-being. These are: a loss of social identity; a loss of social connectedness; and losses associated with disintegration of the body.⁴ Rather than necessarily being a clearly defined event, Norwood considers social death as a series of losses.⁵ For example: loss of identity; loss of ability to take part in daily activities; and loss of social relationships. Cumulatively, these losses can result in an individual becoming disconnected from social life.

Although the concept is present in a diverse range of contexts, a unifying feature is that it is used to comment on the way people may be regarded as if they are something other than human or no longer a person. Being perceived as such manifests itself in not being -

either directly or indirectly - treated as a person and being denied the rights of a person. Below are a few examples of how the concept of social death has been used analytically to demonstrate, and in some cases problematize, the ways in which people are treated differently either before or after physical death.

Social death before physical death

Sweeting and Gilhooly view dementia as an illustrative example of social death.⁶ They argue that those suffering from dementia have already undergone a loss of personhood as a result of their condition. Additionally, since most are elderly, people presume them to be nearing death. This makes it easier for others to perceive people with dementia as socially dead. They studied this by asking caregivers about the extent to which they considered the person to be 'as good as' dead and if their life was worthwhile. They also noted behaviours that suggested discounting the person with dementia in social terms, including not being acknowledged during group interactions. Others have extended this research to discuss how people living in institutions may experience social death as they become distanced from their previous social lives and relationships, together with the isolating and de-personalising activities in care homes.⁷ In many of these studies, social death involves the loss of identity and personal agency. Here, agency is the ability to act independently and to influence the outside world or others, or to resist interventions by others. These losses, and associated social death, can be upsetting and painful for all involved, including the family and caregivers who witness and may contribute to this separation.⁸

Sudnow defined social death as treating the patient as a corpse, although their body may still be physiologically functioning.⁹ His analysis is based on observations of the phasing out of the attention given to dying patients. This occurred when healthcare professional's perceived the patient to have less social viability, and pre-empted the patient's death. For example, autopsy permits were filed and obtained from relatives before elderly patients died. For Sudnow, social death is not just about an asocial treatment of the person per se. It is also about the increasing importance of the body as the focal object in how the patient is discussed and how the dying process is managed. His work outlines the practices that mark how socially relative attributes of the person ceased to be operative in how professionals interacted with patients.

Lock suggests that the risk of experiencing social death before physical death is that someone may undergo a loss of moral entitlement.¹⁰ This concern was formulated during her work about brain death and how people in various stages of unconsciousness may be treated as dead or alive in different cultures. A more commonplace example can be found in cardiopulmonary resuscitation (CPR) research. Studies have demonstrated the ways in the perceived social value of a patient influences clinician's decisions to resuscitate, regardless of the patient's likely survivability of the intervention.¹¹ Therefore, a patient considered to be socially 'as good as dead' is unlikely to receive the same treatment as a patient who is considered to still actively be part of other people's lives and to have a viable social identity. This is even if they have the same physical condition and likelihood to be successfully resuscitated. Importantly, these differences do not necessarily result from the ageism of healthcare professionals, for example, but

because they work within systems that support such decisions. The concern then is that inequality can be perpetuated through perceiving patients as having experienced social death prior to physical death.

In the above examples, someone experiences social death based on the perceptions and actions of others that create and maintain their disconnection from social relationships and activities. However, social death is not always the result of action by others. Lawton suggests that patients with terminal conditions in hospices may actively turn away from life, thereby choosing to have a form of social death prior to their physical death.¹² Similarly, Caswell and O'Connor describe how people may isolate themselves prior to death and die alone.¹³ These actions are often viewed negatively within societies that portray a good death as one where people are surrounded by family and friends. Nevertheless, these examples are illustrative of social deaths where isolation may occur but agency is not lost. This challenges the conceptualisation of social death as a loss of agency or personal identity.

Social death after physical death

Social death can also occur after physical death. An example frequently provided in research involves funerary practices that ritualistically mark the transition of the deceased person from the realm of the living to that of the ancestors.¹⁴ These rituals may be beneficial for the bereaved and help make meaning from the death.

Some bereaved people may seek to keep the 'dead alive' through acts that preserve the identity of the deceased person. This is termed continuing bonds, and can be considered as part of the grieving process as well as a potential risk factor for complicated grief.¹⁵ Examples include continuing to visit and interact with the deceased's social media profile or keep objects belonging to the deceased in prominent places within the home.^{16,17} Similarly, people who experience disenfranchised grief may seek to make their loss real, for instance, through the creation of memorials. For example, perinatal losses may not be considered the death of a person by some, and families can sense a lack of appropriate recognition of the social death and their loss without such markers.¹⁸ Collectively, these kinds of actions have led to the suggestion that social death may not occur until someone is forgotten. It may not be clear when this happens and it can be a gradual process.

Finally, bereaved people may experience their own kind of social death resulting from isolation caused by caring for someone as they were dying and/or stigma attached to grief in different cultures.^{2,19} Bereaved people may also feel isolated as health and social care professional contact diminishes after someone has died. In addition to the loss of social activity, they may experience a loss of identity and role.²⁰ The permanency and significance of this varies across individuals, relationships, and cultures. Professionals can be mindful of how they manage the transition and reduction of contact after someone has died.

Discussion

Distinguishing between social death from physical death enables a form of analysis that identifies the ways in which people may or may not be treated as persons, have their agency acknowledged, or be considered an active participant in social relationships. From a clinical perspective, being sensitive to the ways in which social death may occur can keep one attuned to how perceptions of and changes in interactions with patients can (often inadvertently) result in treating them differently and may place their moral entitlement to treatment and care at risk.

Goffman noted that healthcare professionals would often speak to each other about patients as if they were inanimate objects, even if they were present during the conversation. He considered this as treating patients as non-persons.²¹ Given that the clinical and scientific discourse of healthcare requires professionals to objectify patients to a certain degree, there is a need to ensure this does not result in their dehumanisation. Healthcare professionals can avoid treating patients as if they are (socially) dead through being reflexive about how they talk about patients.

Within end-of life-care policy, one suggestion for preventing social death before physical death is to promote the person's agency, particularly if they may lose the ability to do this in the future.²² This can be done through: the use of advance care planning; increased opportunities for patients to express their identity; and acknowledging their views in discussions with and between healthcare professionals. Such approaches place value in a person's perceived presence and social identity.

Where social death represents an emphasis on the body, it is important that those working with and caring for people and their bodies think about how their interactions might enable social death. This can happen, for example, by over-emphasising disease management. Sampson et al. suggest that alternative therapies provided as palliative care may help people feel like they are treated as a person.²³ This is because they minimise the emphasis on disease and view the body as a site of respect. Such interactions may be restorative for the patient by focusing on their well-being. Consequently, handling the body in ways that are perceived to maintain dignity and one's personhood can be helpful when there is a risk of social death.

The concept of social death is not without criticism, not least because of the variation in its uses.⁴ Using the concept can reinforce mind/body distinctions that perceive the loss of one's cognitive abilities or bodily integration as more or less important than the other, and that a loss of either can result in the loss of personhood, social identity, and/or social relationships. Moreover, the emphasis on agency that is prevalent in many of the definitions and responses to social death presume that agency is a key feature of personhood. This can be a problematic stance and limited view of personhood.

There may be a tendency to think that an ideal death is one in which social and physical death occur simultaneously.²⁴ Most of those who make use of the concept of social death do so because they recognise that it can be distinct process, even if it is not always clear when either form of death actually occurs. If we take mortuary rituals into account, it is rare that both occur at once.¹⁴ Therefore, social death can occur either before or after

death, but making this distinction is not always helpful. It is important to remember that someone may be treated as socially dead by some parties whilst at the same time be considered as alive and socially active for others.² Those who do so may not intend to create or maintain the social death of another person. Nevertheless, treating someone as if they are dead before their own physical death can have significant consequences for the kinds of social interaction they are part of and care they receive.

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